OhioHealth

PATIENT SCHEDULING/REFERRAL FORM

OhioHealth Physician Group
Breast & Cancer Surgery

Patient information:

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip code: _____

Main Phone#: _____ Alternate phone #: _____

Social Security Number: _____ Birth Date: _____

Language: _____ Interpreter: ☐ Yes ☐ No Special needs: _____

Referring Physician information:

Physician's Printed Name: _____ Physician Signature: _____

Office Phone #: _____ Fax#: _____ Form completed by: _____

Reason for Referral: _____

Diagnosis Code: _____ ***If BWC – Allowed Diagnosis Code:*** _____

☐ **Evaluate and Treat** ☐ **Consultation Only/Second Opinion** ☐ **Other** _____

Insurance Information: **SEND COPY OF INSURANCE CARD (FRONT AND BACK) - AND ANY RELATED PATIENT RECORDS / REPORTS**

Referral / Authorization/ Claim # _____ Insurance Company: _____ ☐ Self Pay

☐ BWC Employer _____ Date of Injury _____

MCO Name _____

Patient Needs an Appointment: ☐ **ASAP** ☐ **Within one week** ☐ **Patient's Convenience** ☐ **Office to call patient** ☐ **Patient to call office**

Physician Consulted	**Circle location preference**
☐ Natalie Jones MD	1 2
☐ Deepa Halaharvi DO	1 2

FAX: (614) 533-0124 Phone (614) 566-2280

1. 500 Thomas Lane Suite 2B Columbus, OH 43214
2. 7450 Hospital Dr Suite 340 Dublin, OH 43016

Physician Consulted	**Circle location preference**
☐ Mark Cripe DO	1 2
☐ Christine Habib MD	3 4 5
☐ Deepa Halaharvi DO	1

FAX: (614) 533-0438 Phone: (614) 566-0774

1. 285 E State Street Suite 300 Columbus OH 43215
2. 5141 W. Broad Street Suite 180 Columbus OH 43228
3. 4882 E. Main Street Suite 110 Columbus OH 43213
4. 300 Polaris Parkway Suite 1050 Westerville OH 43082
5. 1010 Refugee Rd Suite 310 Pickerington OH 43147

Mark Area of Concern

☐ Abnormal imaging	☐ right	☐ left	☐ both
☐ Breast lump	☐ right	☐ left	☐ both
☐ Breast Pain	☐ right	☐ left	☐ both
☐ Nipple Discharge	☐ right	☐ left	☐ both
☐ Cancer	☐ right	☐ left	☐ both
☐ High Risk			
☐ Other: _____			

Patients to hand carry any films and reports to their appointment if not done at OhioHealth.
Do not mail reports

APPOINTMENT INFORMATION: Return to referring physician

Date Scheduled: _____ Time _____

Physician _____ Location _____

Appointment Info back to referring physician ☐ Faxed ☐ New patient packet mailed Date: _____

5/13/19